REMARKS ON IMPOTENTIA COEUNDI AND SEXUAL NEURASTHENIA AND THEIR TREATMENT.*

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As the title of this paper signifies, I have no intention in the brief time allotted to me to even try to cover this vast subject. Any one sufficiently interested will find everything of importance in some of the recently published monographs. I will not classify the various types according to their pathological and physiological bases, but will endeavor to call attention to certain well known and frequently observed conditions, and when necessary, to illuminate and emphasize them by briefly citing histories of patients observed by me. If I am successful in only slightly stimulating the interest of the medical gentlemen present in this most important subject my object will have been attained; for in the past these unfortunate patients have been unable to get any relief from their logical medical advisers and have been considered the legitimate prey of the advertising quack.

I take it for granted that my audience is acquainted with the physiology of the sexual act.

It is evident that anatomical defects, epispadias with ektopia vesica, hypospadias perinealis and scrotalis, destrucion of penis by gangrene and phagedenic ulcerations, tumors of penis, etc., are more or less prohibitive to connection. Plastic indurations of corpora cavernosa (induratio penis plastica) by causing excentric erections or pain. The etiology of this complaint is usually considered to be syphilis, diabetes or gout. I believe it to be due in most cases to a slight fracture or oft repeated trauma of the corpora cavernosa during coitus. I have under observation five cases in three of which a Wassermann test was made and found negative. Only one of these patients was unable to have connection on account of the pain caused by the erection destroying all desire with a consequent collapse of erectile tissue.

The loss of sexual desire is frequently the first symptom that makes patients seek medical advice, with the result that a chronic nephritis or a diabetes mellitus is found. It stands to reason that this should occur in the last stages of these diseases, but I have found loss of potency early in nephritis and diabetes in a number of my cases. Chronic alcoholism also in a small percentage of cases causes early impotence.

Locomotor ataxia either causes early loss of potency, or, as a number of my patients complained, erections lasting an hour or more without ejaculation or orgasm. Gout may also be considered one of the early causes.

A large contingent of our patients belong to the class that we may term "nervous impotence": Patients who have no pathology in the sexual organs with the exception that they feel unequal to the sexual act and that they possibly have a general neurasthenia or that it is only a symptom of hypochondriasis.

1. A young man of neurotic antecedents, himself bearing the stigmata of neurasthenia, with no history of onanism, no previous sexual connection, marries a young woman and is sent to me by Dr. Hunkin two weeks after marriage with the complaint that he is unable to have intercourse. Careful examination of genitalia with negative findings; history of a fair erection at the first attempt with gradual reduction in size and duration of erections.

2. An attorney who after the death of his first wife remained continent for a period of about a year, upon again marrying found himself impotent with the result that each attempt made conditions decidedly worse. Examination showed a normal condition of genitalia. He was told after this examination to not attempt coitus for one week, when I would re-examine him. This proved satisfactory, as he telephoned two days later that he had entirely recovered.

3. A teacher of mathematics consulted me concerning an impotence that had developed during and after a period of very intense application to his vocation. In this case a loss of erection resulted at each attempt as problems would present themselves at that time. No pathology in genitalia. Alcoholic stimulation advised with satisfactory results.

Relative Impotence. This is a state where a man may be potent with all other females but impotent with one. An attorney who had been forced to practice coitus interruptus with his wife for a period of time got all the symptoms of irritable weakness. After proper treatment he found himself impotent as far as his wife was concerned. This case is part of the record of the divorce court.

Impotence on the Basis of a Gonorrhea with prostatitis vesiculitis and the consequent changes in the posterior urethra is very frequent. Patients complain of precipitate ejaculations, flaccid erections, neuralgic pains and paresthesias of genitalia, frequent urination, imperative urination, or sometimes a difficulty to start stream. These people have usually had injections, sounds, electricity, baths and treatment at springs. Upon examination of prostatic and seminal vesical expressate many pus cells, gonococci (?) and bacteria are found. The endoscope shows marked changes in the posterior urethra, caput gallinaginis, etc. The Goldschmidt instrument has taught us that many cases formerly considered of nervous origin with no pathologic basis really are due to definite changes in the posterior urethra. This picture is so common that I need not bore you with illustrative cases; suffice it to say that massage of prostate, stripping of vesicles, autogenous vaccines and topical applications will give results in practically all cases if skilfully done and persevered in.

Another type of post gonorrheal impotence is in those cases where no gonorrheal residual is to be found, where the patients have been well treated, perhaps too energetically; sounds, dilatations, caustics, etc. In some of these cases we undoubtedly deal with irritable weakness or what is slightly rarer, an atonic impotence, i. e. hyperesthesia of the mucosa of the posterior urethra, colliculitis seminalis; or, on account of changes in the terminal nerve fibres of the posterior urethra, a more or less marked anesthesia. This same picture we find in cases of excessive onanism, coitus interruptus and sexual excesses.

In the hyperemic type of cases, topical applications through endoscope, prostatic sounds, hot sitz baths, etc., etc., will many times give the expected result.

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In the anesthetic cases it depends largely upon the severity of the case. Very marked local irritation, faradic current, curetting of mucosa of posterior urethra, will often give results in cases declared hopeless.

Precipitate Ejaculation (ejaculatio præcox) frequently occurs in normal individuals, the ejaculation being accompanied by a satisfactory orgasm. This occurs in patients who have been continent for some time or frequently in the face of a new love affair. A fairly large dose of bromide, or a large glass of pilsner frequently exerts a sufficient inhibition. Otherwise morphin is an excellent remedy.

This same symptom accompanied by a deficient erection, absence of orgasm and distinctly disagreeable sensations is either a manifestation of irritable weakness or one of the initial symptoms of paralytic impotence. Endoscopic examination shows an abnormal hyperemia, a sodden swollen condition of the mucosa of the posterior urethra and colliculitis. The urine examination shows a chronic posterior urethritis and the patients complain of disuria, painful urination, spasmodic contractions of sphincter. Neuralgic pains during ejaculation are due to the irritation of inflamed prostatic urethra.

Retarded Ejaculation. This is not unusual in men who have lived rather an active sexual life, and if not accompanied by disagreeable sensations and exhaustion, they will hardly come to a physician for advice. I have seen several such cases, they being medical men, and two lawyers who were apprehensive of the future. A not uncommon condition is retarded ejaculation where only after physical exhaustion ejaculation takes place accompanied by disagreeable and painful sensations.

Orgasm. The orgasm is the feeling of sexual delight or satisfaction that takes place when the semen enters the prostatic urethra. The decrease or even absence of orgasm is a frequent complaint and is usually a warning for a more rational sexual life.

Seminal Emissions. Nocturnal emissions are normal to the degree that when pressure occurs in the seminal vesicles the reflexes are set in motion and the emission takes place accompanied by an erection and an erotic dream. This is followed by no depression physical or mental. The character of the dream is characteristic.

Frequent or Heaped Nocturnal Emissions. Sexual overexertion, frequent and repeated cohabitations cause an irritability of the spinal genital centers, which during sleep may cause frequent emissions. Accompanying these we usually find general nervous exhaustion, impotence, dyspeptic symptoms and great psychic depression. This condition may lead to the graver symptom of diurnal emissions, which take place upon the simplest erotic stimulation, i. e., sitting next to an attractive woman, literature of the erotic type, etc., an erection followed immediately by ejaculation.

In case the irritation of the genital reflex centers has reached the maximum, ejaculation takes place without erection or orgasm, leaving the patient terribly depressed, faint, etc.

Spermatorrhea and Prostatorrhea. Occasionally this takes place in normal individuals who have been continent for some time or who are constipated. In the pathological conditions either prostatic, or material from the seminal vesicles is found after every stool and micturition. The patients complain of weakness, headache, neuralgic testicular pains. The secretion, with the gravity of the condition, changes up to a period of the absence of spermatozoa.

Urethrorrhea ex Libidine. I mention this only because many patients consult you for what seems to them a grave condition, which is really a hypersecretion of the anterior urethral, Cowpers, Littres and Morgagnis glands. Microscopically mucous and epithelial cells are found. This is frequently present in cases of excessive masturbation, long continued sexual excitement and after treatment for urethral inflammations of long standing.

Sexual Neurasthenia. One of the earliest symptoms is a hyperirritability and sensitiveness of the skin of the genitals; marked hyperesthesias and parasthesias of the skin of the penis and scrotum, principally the glans. Sometimes this is caused by phimosis, balanoposthitis, etc., but usually nothing pathological can be found. Patients complain of terrible pain of glans, either due to touch or spontaneous in type. This hyperesthesia may take in the scrotum, urethral and bladder mucous membrane, causing disuria, etc. Patients have to void the urine on account of pressure and this act is accompanied by pain, burning and disagreeable sensations of the penis and anal regions. Neuralgias of testicles and prostatic gland may be present. Ejaculation is painful to the point of torture, this being the case during emissions as well as during copulation. This is the reason for the intense depression as well as the rapid onset of general symptoms. Endoscopically we find inflammatory changes and hypersensitiveness near the meatus and in the prostatic urethra. Frequently we find pruritus of the scrotum, perineum and anus, and a number of such sufferers who consulted me, and who had run the gamut of dermatologic advice, were cured after the correct diagnosis had been arrived at. A feeling of cold or chilliness of the genitals and even large portions of the body is quite frequent. Hyperhydrosis of the genitals is not infrequent, and is complained of on account of the moisture, feeling of cold and particularly on account of the odor. The penis occasionally seems smaller and definitely decreases in size when exhibited or on attempted intercourse. Frequent micturition (painful?) particularly in the daytime is a marked symptom.

Disuria and stranguria nervosa are brought about by hyperemia and inflammatory swelling of posterior urethra. Later disuria is present even at night. Frequently patient does not feel the satisfaction of having emptied his bladder, having the sensation of residual urine.

In the second stage of this disease all symptoms are aggravated, with pains in the back, rectum, anus, radiating towards kidneys, thighs and even feet; formication, inability to stand for long periods and marked weakness in limbs after emissions. The pain in region of kidney may simulate renal colic, and I had a case X-rayed and had made a tentative diagnosis of stone only to find my error a little later.

The third stage is practically an aggravation of symptoms of the second stage with the addition of marked symptoms of general neurasthenia; rheumatic lancinating pains of trunk, headaches, hemicrania, marked hyperesthesia of skin, general feeling of cold, formication, etc.; a feeling of general exhaustion, inability as to muscular effort; tremors, exaggerated reflexes; serious dyspeptic disturbance, constipation alternating with diarrhea, flatulence, phosphaturia and oxaluria.

The Treatment of Neurasthenia is very difficult and only individualization, careful removal of all pathology from genitals, a moral and sexual hygiene, full control of your patient, hydrotherapy, a correct and active life will, after some failures, frequently accomplish a cure, or at least a marked amelioration. One must not lose track of the fact that these people have no resistance, and that the slightest causes may bring about a relapse.

A young man with all the symptoms of the second stage of sexual neurasthenia was sent to me in 1902, and after eighteen months of tedious and careful treatment and general direction he married and remained well with the exception of occasional slight symptoms. One year ago his wife went to Europe, and living at his club he committed a few excesses in venere and baccho, with the result that six months ago he came to me with a very severe relapse. Only recently he has sufficiently recovered to take up his marital relations, and his wife has been duly informed as to his antecedents.

A CASE OF FILARIASIS TREATED BY THE WHERRY-McDILL METHOD.*

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As is always the case in the treatment of any incurable complaint, there are a large number of remedies offered for the cure of filarial chyluria. The principle ones are gallic acid in large doses, benzoic acid in large doses, glycerin, tincture of the perchlorid of iron, decoction of mangrove bark, chromic acid, quinin, salicylate of soda, ichthyol, nigella sativa, thymol, and methylene blue.

Commenting on these remedies, Manson says that he does not believe that those substances have any influence whatever in stopping the lymphorrhagia. Probably the latest suggestion for the cure of chyluria is that offered by Drs. Wherry and McDill.

Five years ago these authors reported a case treated by thorough cinchonization and subsequent exposure to the X-rays. Their patient was given 80 to 90 grains of quinin sulphate during forty-eight hours and was then submitted on alternate days to the X-ray. From time to time the cinchonization was allowed to cease and the patient permitted to rest for a few days. That their radiation was energetic was evidenced by their report that the skin over the chest and abdomen became red and hot. Their patient also experienced in the way of complication, a left pleurisy, which yielded 600 cc. of fluid. At that time they report that the patient's skin over the entire body became scarlet. "All this time the urine remained thick and bloody but now became normal and has remained so." The temperature throughout, except during the pleurisy, remained about normal. The patient gained strength and weight and improved in general appearance, except during the time of the pleurisy. Although the patient was discharged from the hospital and was up and about for two months, the chyluria did not return, although the living embryos still persisted in her blood.

Three years later these authors make a second report as follows:

"The hematochyluria cleared up on October 10th, 1904. Two months later filarial embryos were still present in the peripheral blood, but repeated examinations since, made about once a year, have failed to reveal the embryos. The last examination was made one year ago, 1908. The patient is now in Nagasaki and said to be in good health."

This experience was so encouraging that I decided to elect this treatment for my case: the history of which, abridged, is as follows:

On December 10th, 1909, I was consulted by Harry Uyeno, a Japanese, aged 29, who had come from Japan six years before, stopping at Hawaii three months on the way. In 1905, he took a trip to Alaska and on his return to Oakland, in 1907, developed for the first time hematochyluria, which continued during August and September. The next year, 1908, he had his second attack which began in July, lasting through August and September, disappearing, curiously enough, in the same month as his first attack. It was during his third attack, in 1909, that he came to me saying that the chyluria had continued steadily during September, October, November and December, of that year.

The patient was fairly well nourished and complained of no symptoms except general weakness and milky urine. A physical examination was negative. His pulse was 100, temperature 98. His blood, taken at midnight, showed a great many sheathed filarial embryos. The urine was very milky and colored by blood. It did not contain any embryos. Sp. Gr. 1028, reaction slightly acid, albumen present, but no fat. Blood-count gave the following percentages:

Polymorphonuclear neutrophiles (includes transitionals)	46%
Lymphocytes	29%
Large mononuclears	14%
Eosinophiles	11%

After consultation with Dr. Creighton Wellman, the patient was put on the Wherry-McDill treatment. To give a detail account of the treatment which was pursued from the middle of December to the middle of April, four months, both at home and in a hospital, would be tiring and probably unprofitable. Suffice it to say that he was immediately cinchonized so thoroughly that he could scarcely make the journey to my office for the X-ray exposures. The quinin taken, varied from 15 grains per day to 120. By December 31st, at which time I had given only two X-ray exposures the urine became perfectly clear and of normal sp. gr. with no trace of albumen, the first time the urine had been clear for four months. The number of embryos in the peripheal circulation deceased markedly. The patient improved in that he was more ambitious, though his weight did not change materially. Wishing to clinch the cure, the quinin was continued, in moderate doses, and the patient exposed to the X-ray once a fortnight. It appeared that I was to have the pleasure of reporting the second cure under this treatment. But on February 7th, and intermittently thereafter, the hematochyluria reappeared.

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